Centre for Technology Development
Women-in-Development

A Qualitative Study of Quality of Care in Rural Karnataka

by

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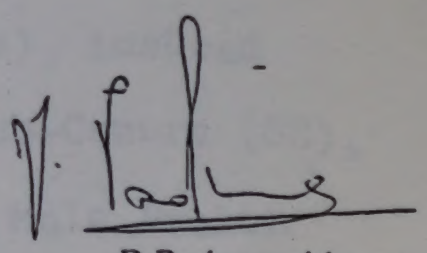
Introductory Note

The Centre for Technology Development (CTD) is a non-governmental registered society established in 1988 with USAID assistance. Among its mandates is the programme relating to Women in Development (WID) which has the primary focus on Education, Employment, Enterprise and Empowerment of women. Empowerment includes entitlement to health care not only for women but for children too, and the recognition of the reproductive rights of women. Under this mandate of WID, the CTD has established the Centre for Population Dynamics (CPD), as one of its Divisions, for evolving and implementing schemes and programmes relating to maternal and child health and reproductive health.

The CPD has held consultations with expert groups to determine a framework for its activities, particularly in the context of the growing consensus after the recent UN Conference at Cairo that the family welfare programme, essential as it is, should be implemented more appropriately as an integral part of programmes meant to improve reproductive health. Based on the conclusions of expert group discussions, and taking into account the findings of the National Family Health Survey for Karnataka, it was noted that the quality of health and family welfare services was a crucial determinant in their acceptability and utilization.

The concern of the CPD in issues relating to the quality of health and family welfare services has been expressed in various technical meetings of expert groups. In this context, a paper was presented by Dr. P.H.Reddy on behalf of the CPD at the seminar on "Quality of care in Indian Family Welfare Program" organized on 24-26 May 1995 in Bangalore by the Population Council. The paper entitled "A Qualitative Study of Quality of Care in Rural Karnataka" is reproduced in this publication. It investigates the process of interaction between the providers of family welfare services and the clients with emphasis on the quality of the services in Karnataka. Though the paper is based on a study in this State, its conclusions would be of general relevance to the management of the family welfare programme.



P.Padmanabha

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INTRODUCTION

The Third Five-Year Plan (1961-66) of India set a demographic goal of reducing the crude birth rate in the country to 25 per 1000 population by 1973. This goal has not been achieved even today. Later, several demographic goals were set to be achieved by specified years, but they were either deferred or revised upwards. A major reason for the failure to achieve the goals was thought to be lack of adequate infrastructural facilities for the family welfare programme. Therefore, it was decided to improve institution-population ratio and worker-population ratio.

The national norm for rural areas is to have one Primary Health Centre (PHC) for every 30,000 people (one PHC for 20,000 people in hilly and tribal areas), instead of one PHC for every 100,000 people, and one Sub-Centre (SC), with one auxiliary nurse-midwife (ANM) and one Male Health Worker, for every 5,000 people (one SC for every 3,000 people in hilly and tribal areas), instead of one SC for every 10,000 people.

Only recently have the policymakers started thinking about the importance of, and the need for, improving the quality of family welfare (maternal and child health, and family planning) services in hastening a decline in the birth rate.

How does one go about defining quality? The international Organisation for Standardisation defines quality as "the totallity of features and characteristics of a product or serivce that bear on its ability to satisfy stated or implied needs" (Raghupathy, 1992: 18). The quality of a product can be more easily monitored and measured than that of a service because, "unlike a product which is a tangible good, service is an activity or process generally between a customer and a service employee" (Raghupathy, 1992: 18).

What is meant by quality of care or quality of family welfare services? There are some explanations of quality of family welfare services, but the last word about the quality of family welfare services is yet to be said. According to Jain (1989: 1-16), Bruce (1990: 61-91), and Jain and Bruce (1989: 6-8), quality of family welfare services incorporates the following six elements: (1) choice of methods, (2) information given to clients, (3) technical competence, (4) interpersonal relations, (5) mechanisms to encourage continuity and (6) appropriate constellation of services.

The six elements that are said to reflect quality of family welfare services do not appear to be exhaustive. It is true that technical competence of providers influences the quality of services. But equally important are the attitudes of the providers towards the concept and different family planning methods as well as towards the clients.

Family welfare services are not merely a service sector. They also represent elements of a manufacturing sector in the sense that products like Cu-T, condoms and oral pills are used. There will be loss or no demand for them if their quality is poor.

A study conducted in Karnataka (Reddy and Gopal, 1988) has revealed wide gaps in the knowledge, skills and practices of medical, paramedical and non-medical personnel. The situation would not be different in the other parts of the country.

An evaluation study conducted by a task force of the Indian Council of Medical Research (ICMR, 1991) has revealed that the quality of pre-natal, intranatal and post-natal services in the country was poor; quality of immunization services for children was poor; and, the quality of family planning services was no better.

In their study in Gujarat, Visaria and Visaria (1992: 113-138) have identified problems related to the quality of

family planning services, especially with regard to the choice of family planning methods, services for spacing methods, venue of sterilisation, pre- and post-sterilisation care, etc.

A qualitative study of client's view of quality of health and family planning services in rural Uttar Pradesh has revealed a number of signals of quality of care such as experiences with effectiveness of treatment, thoroughness of examination, care by a doctor, waiting time, etc, (Levine at al., 1992: 247-265). Reviewing various studies, Khan and Patel (1993: 114-115) have identified various aspects of family welfare services in Uttar Pradesh that were poor.

A study in Karnataka, Tamil Nadu and West Bengal has revealed both clients' and providers' perspectives on quality of "family welfare services and care" and relationship between perception of quality and utilisation of services (Verma, Roy and Saxena, 1994). The findings with regard to clients' perspectives are as follows: eligible women's perception of various components of quality of services varied from district to district within the same state; doctor's behaviour was perceived to be better than the other three dimensions of quality, namely, workers' services, facilities at PHCs and accessibility; and, there was little variation in the perceive quality of services by women's age, education and caste. The findings with regard to providers' perspectives are as

follows: there was a wide interdistrict variation in the level of knowledge and motivation of workers; organisational climate followed different patterns in different states; pressure of achieving sterilisation targets was felt high by the majority of workers in all the three states; and, maintenance of eligible couples' registers was not adequate in all the three states. The findings with regard to relationship between perception of quality and utilisation of services are as follows: clients' perspectives on quality of services influenced the utilisation of health and family planning services; and, follow-up services by workers influenced the utilisation of health and family planning services by the clients.

As Khan and Patel (1993: 114) say, "... there is hardly any study which has systematically addressed all the six elements of quality of care." Moreover, the number of studies of quality of care in India are small and those employing qualitative methods even smaller. There is, therefore, an urgent need to study the quality of family welfare services in different parts of India, especially employing qualitative research methods.

OBJECTIVES OF THE STUDY

The broad objective of the present study is to throw light on the quality of interaction between clients and

providers, and the quality of family welfare services. More specifically, the study examines

1. how family welfare programme personnel interact with clients in a given setting;

2. quality of such interaction;

3. how frequently interaction takes place;

4. provider's view of, and satisfaction with, the information and quality of family welfare services provided; and,

5. client's view of, and satisfaction with, the information and quality of family welfare services received.

The focus of the investigation is on the family welfare programme, that is, on the maternal and child health (MCH), and family planning programmes.

STUDY INSTITUTIONS

It was earlier decided to select randomly one district, two Primary Health Centres (PHCs) in that district and three Sub-Centres (SCs) under each of the two PHCs. Accordingly, Kolar district was selected. The two PHCs selected were Masthi and Vokkaleri. The three SCs selected under Masthi PHC were Dinneriharohalli, Kudiyanur and Santhehalli; the

three SCs selected under Vokkaleri PHC were Arabikothanur, Beglihosahalli and Settykothanur. Of the six SCs, only two SCs had Male Health Workers in addition to ANMs, one under each of the two PHCs.

In Karnataka, perhaps as in other states, there are two types of PHCs: one type established under the Minimum Needs Programme (MNP) and are called MNP-PHCs; the other type established under the Government of India pattern (GOIP) and are called GOIP-PHCs. The latter cover a larger geographic area and hence a larger population, and have more staff members than the former. At the time of writing, of the 1,357 PHCs in Karnataka, 1,088 are MNP-PHCs and 269 GOIP-PHCs. It so happened that, of the two PHCs selected for study, one was MNP-PHC(Masthi) and the other GOIP-PHC (Vokkaleri).

The Masthi PHC was established on 12th December, 1983 by upgrading the existing Primary Health Unit (PHU), a smaller health institution than a PHC. It has been functioning in a newly constructed building from 24th May, 1994. It covered 113 villages, including Masthi, and a population of 49,197 (according to the 1991 census). It had 15 SCs, including the one at the PHC. The Medical Officer of Health (MOH) could not give information on the area covered by the PHC.

The Vokkaleri PHC covered a population of 70,158 and an area of 185 Km^2. It had 11 SCs, including the one at the

PHC. The MOH has been on unauthorised absence for the las eight months. The Lady Medical Officer (LMO) could not gi information on the date of establishment of the Vokkaleri P and the number of villages covered by it.

The number of villages served by the three selected SCs under the Masthi PHC varied from five to seven and the population served by the three SCs from less than 2,000 to over 4,000. The distance of the villages from their SC headquarter varied from one kilometre to 11 kilometres. Th names and population of the villages served by the three selected SCs under the Masthi PHC and their distance from the SC headquarter are presented in Annexure I.

The number of villages served by the three selected SCs under the Vokkaleri PHC varied from six to eight and the population served by the three SCs from a little over 3,500 to a little over 5,000. The distance of the villages from their SC headquarter varied from ½ kilometre to seven kilometres. The names and population of the villages served by the three selected SCs under the Vokkaleri PHC and their distance from the SC headquarter are presented in Annexure II

An immediate observation that can be made is that the number of villages and the population served by a SC under GOIP-PHC (Vokkaleri) were larger than those served by a SC under MNP-PHC (Masthi).

No family planning clinics were conducted in the Masthi PHC, as the MOH was not trained in conducting vasectomies and tubectomies. Therefore, all the women who wanted to adopt tubectomy or laparoscopic tubectomy from the area of the Masthi PHC were sent to the nearest general hospital at Malur, the taluka headquarter. The LMO of the Vokkaleri PHC was trained in conducting tubectomies and she occasionally conducted tubectomies in the PHC. But a vast majority of the women who wanted to adopt tubectomy or laparoscopic tubectomy from the area of the Vokkaleri PHC were sent to the nearest general hospital at Kolar, the district headquarter. While the LMO performed tubectomies at the Vokkaleri PHC whenever there were three or four women, tubectomies were done in the general hospitals at Malur and Kolar on every Friday, and laparoscopic tubectomies twice in a month, usually on the 16th and the 30th.

MATERIALS AND METHODS

Multiple qualitative research methods were employed to collect the required information. These included observation, informal interviews and discussions, semi-structured interviews, and focus group discussions. The advantage of qualitative methods is that "... they produce contextual or holistic explanations for a smaller number of cases, with an emphasis on the meaning rather than the frequency of social phenomena" (Simmons and Elias, 1994: 6).

The method of observation, including occasional participant observation, was employed at the antenatal/immunizat clinics and family planning clinics held in the hospitals (taluka hospital at Malur and district hospital at Kolar an also at Vokkaleri PHC) and activities carried out during field visits of health workers.

Three tubectomy camps each and two laparoscopic camps each at the taluka and district hospitals were observed. In addition, three tubectomy camps at the Vokkaleri PHC were observed. Invariably, at both PHCs and SCs, antenatal clini and immunization clinics were conducted together. Immunization clinics were also organised in villages by spreading information in advance during the visits of the ANMs. Three antenatal/immunization clinics each at the two PHCs, two each at the six SCs and one each in villages under the six SCs were observed. The antenatal/immunization clinics at the PHCs were conducted on every Thursday. But there was no fixed day for conducting these clinics at the SCs and in the villages. Whenever there was sufficient demand, clinics were conducted.

In each of the SCs, an investigator followed the auxiliary nurse-midwife (ANM) for seven working days and observed her activities. This provided an opportunity to observe the ANM in the clinic as well as in the outreach area, that is, in the villages when they were providing services to the community.

One Male Health Worker in a SC under each of the two PHCs was followed by a male investigator. One could be followed for four days and the other for three days. In Karnataka, a high proportion of the posts of Male Health Worker are vacant. The authorities are in no hurry to fill the posts perhaps because Male Health Workers are not considered an asset and the posts have to be supported financially by the state government.

Semi-structured interviews were held with the MOH at the Masthi PHC, the IMO at the Vokkaleri PHC, the six ANMs and the two Male Health Workers and information was collected on their socio-economic background, their educational achievement, experience, attitudes towards the people to whom they were providing services, commitment to the jobs they were doing, etc.

One focus group discussion among the providers was conducted in each of the two PHCs with a view to capturing their perception on quality of care provided at the clinics and during their interaction with clients. The focus group discussions were conducted at the PHCs on the days of their monthly meetings. During the discussions issues such as type of clients covered, problems faced by them in providing services, division of labour between ANMs and Male Health Workers, etc. were addressed.

Focus group discussions were also conducted among the beneficiaries at the rate of two per SC. These two focus group discussions were conducted in the same village covering two different socio-economic groups. One focus group discussion was conducted among the people belonging to upper castes and classes usually residing in the centre of the village. The other focus group discussion was conducted among the people belonging to Scheduled Castes, Scheduled Tribes and other lower castes and classes usually residing in the periphery of the village. The participants in the focus group discussions were mostly currently married women and husbands of such women.

Informal interviews and discussions were held with both functionaries and beneficiaries in order to understand their perceptions on the quality of interaction and family welfare services.

Organization of Field Work

Six investigators were employed to collect data from six SCs, that is, at the rate of one investigator per SC. In addition, two supervisors were employed - one per three SCs, that is, one in each PHC - to help the investigators in the collection of data and to oversee the progress of field work. The Principal Investigator visited frequently the stud

area and not only guided the field work but also observed personally the quality of interaction between the providers and the clients, and also of the family welfare services.

The investigators and supervisors were post-graduates in social sciences. The two supervisors had three years of experience in the collection of primary data. Before the investigators and supervisors were sent into the field, a three-day training programme was organised for them. In the training programme, the nature and objectives of the study, the unstructured interview schedules and guidelines, qualitative methods of data collection and the conduct of focus group discussions were explained. They were given (anthropologists') notebooks in which they were required to record their observations of quality of care from various settings, discussions and conversations. The field work was completed in two months and during these two months the investigators and supervisors lived in the study area and collected the data.

FINDINGS

The Primary Health Centres (PHCs)

In the morning, the premises of both the Masthi and Vokkaleri PHCs were swept and kept clean. But by evening the premises became dirty because people who came to utilise the services threw away papers, banana leaves in which they

brought their food, etc. On some days some clients came by bullock-carts right into the compounds of the PHCs and parke them there. The dung, the grass and the hay dirtied the premises. In addition, hospital staff occasionally threw away bandage clothes and cotton swabs. There were no bins. At the Vokkaleri PHC, there were plants, trees and lawns. They watered the plants, trees and lawns every day. They stored water in a container to water the trees and lawns. Relatively, the Vokkaleri PHC was better maintained than the Masthi PHC perhaps because the former was a GOIP-PHC, while the latter was a MNP-PHC; the IMO lived at the Vokkaleri PHC while the MOH did not live at the Masthi PHC; and, the Vokkaleri PHC was managed by a lady doctor, while the Masthi PHC was managed by a male doctor.

The PHCs in Karnataka work from 8 a.m. to 12 noon and 3 p.m. to 5 p.m. The gates of the two PHCs studied were open on time (8 a.m.). But only one or two staff members came on time. Most reported for work around 10 a.m. Clients also sta coming around 10 a.m. It is difficult to say whether the providers in the PHCs reported for duty around 10 a.m. because the clients came around that time or the clients came around 10 a.m. because the providers reported for duty around that time. The MOH of the Masthi PHC lived in Bangalore and commuted daily by bus covering a distance of 67 kilometres each way. On many days he arrived late at the PHC and left early.

Many clients do not know about the working hours of the PHCs. Generally, educated clients know about the working hours of the PHCs and they know that the PHCs are opened late and the providers come late. When asked whether she knew about the working hours of the Vokkaleri PHC, an ante-natal mother said, "We are illiterate people. We do not know the working hours of the PHC. We wait till the PHC is opened and till the services are provided." When asked about what he felt about PHCs opening late and the providers coming late, a graduate at the Masthi PHC said, "No askers, no tellers. What can I do?" Thus, though educated people know the working hours of the PHCs and resent PHCs opening late and the providers coming late, they do precious little to remedy the situation.

The staff members of the two PHCs were invariably busy with their work. They did while away the time quite frequently while clients waited for services. Generally, the providers were pleasant with the clients. When there were too many clients, providers frowned upon them and tended to be serious so that they could provide services to all the clients in time so that they (providers) were not required to go home late. Some of the providers said that there was no need for them to be serious because their work was "routine" and "mechanical".

At the Masthi PHC, a Lady Health Visitor said, "We are here to provide services to the community. But we want the

patients to remain calm until we provide services to them. We want to provide services to all of them before the PHC is closed for the day." At the Vokkaleri PHC, an ANM remarked: "We are paid by the government to provide services to the peo Therefore, we should not turn away the patients without providing services. But when there are many patients and whe they become unruly we get annoyed slightly. Otherwise we are very considerate and friendly with the patients."

The doctors and other senior staff members at the two PHCs were nice to the clients. But the junior staff members were somewhat rude to the clients, especially when the number of clients was large. The providers did not maintain distance from the clients. Nor did they mix freely with the clients. The interaction was rather mechanical and business-like.

On enquiry, one female patient at the Vokkaleri PHC said, "While doctoramma (Lady Medical Officer) is nice and kind, nursammas (nurses) are somewhat unkind."

The two PHCs provided a range of services, including preventive services, curative services, family planning services, MCH services, school health services, malaria eradication services, Japanese encephalitis control services, etc.

As in other PHCs in Karnataka, antenatal and immunization clinics at the two study PHCs were conducted on every Thursday. While the IMO at the Vokkaleri PHC occasionally

conducted tubectomies in the PHC, family planning clinics, that is, tubectomy clinics were conducted on every Friday in the taluka hospital at Malur and in the district hospital at Kolar. As a policy, family planning camps outside PHCs or hospitals are not held in Karnataka. Laparoscopic tubectomy camps were held twice in a month, invariably on the 16th and the 30th, in the taluka and district hospitals. Since the Masthi PHC was closer to Malur, those who wanted to adopt tubectomy or laparoscopic tubectomy from the Masthi PHC area were taken or sent to the taluka hospital at Malur. Since the Vokkaleri PHC was closer to Kolar, those who wanted to adopt tubectomy or laparoscopic tubectomy from the Vokkaleri PHC area were taken or sent to the district hospital at Kolar.

Family Planning Clinics

Observation of family planning clinics in the taluka hospital at Malur and the district hospital at Kolar revealed satisfactory interaction between the providers and the clients, and the treatment given to the latter by the former was also satisfactory. The ANMs concerned participated in the clinics. First they prepared their "cases" for tubectomy or laparoscopic tubectomy by washing the abdomen with soap and water. They also helped in the laboratory examination and in giving injection, streptopenicillin test dose, and soap and water enema. The women were also tested for diabetes and HIV infection. Then they were seen arranging snacks, coffee, tea, etc. to their clients. The clinics were conducted under fairly

satisfactory sanitary conditions. Informal discussions with women, both before and after adopting tubectomy and laparoscop tubectomy, indicated that they were satisfied with the treatment given to them by medical and paramedical personnel and with the quality of care received by them. The ANMs concerned were on hand to assist, in any way necessary, both before and after the operations. In fact, the women who adopted tubectomy and laparoscopic tubectomy said that if they did not receive good treatment and good quality of care, it would be difficult for the ANMs to motivate women for family planning in future.

A woman aged about 26 years waiting for tubectomy in the Malur taluka hospital siad, "My mother and I have come here in the morning. Our ANM has told me that the operation (tubecto will be performed in the afternoon. Doctors and nurses of this hospital are not unkind. But our (Sub-Centre) ANM is nice. She is taking good care of us."

Another woman aged about 25 years waiting for tubectomy at the Kolar district hospital said, "our ANM looks after us well because she has to bring other women for operation."

Yet another woman aged about 28 years waiting for laparoscopic tubectomy in the Kolar district hospital said, "This is a big hospital and doctors and nurses are very busy. But they will perform current operation (laparoscopic tubectomy) on me this afternoon. We should have patience. However, our ANM is looking after me well."

Further observation of the family planning clinics revealed three negative aspects or drawbacks. One, the ANMs admitted the women to the family planning clinics at 9.30 a.m. But the case preparation started at 11 a.m. or 12 noon. Doctors who performed tubectomy or laparoscopic tubectomy turned up anywhere between 2 p.m. and 4 p.m. The operations were over around 6 p.m. Thus the clients were required to wait for a long time.

When asked about what they thought about waiting for a long time in the hospitals for tubectomy and laparoscopic tubectomy, one woman in the Malur taluka hospital said philosophically, "The necessity is ours. Therefore, we have to wait until doctors and nurses turn up. Perhaps they are busy with other patients." Another woman who was waiting for laparoscopic tubectomy in the Kolar district hospital said, "We are poor and rural people. We cannot force the doctors and nurses to perform laparoscopic tubectomy on me immediately. We should wait patiently for our turn."

Two, it was observed that the women who came for tubectomy and laparoscopic tubectomy were given prescriptions by the doctors to buy pre- and post-operative drugs. The women bought the drugs and gave them to the doctors for administration. As a matter of fact, hospitals are expected to provide these drugs free of cost.

On enquiry about the necessity to purchase pre- and post-operative drugs, one woman at the Malur taluka hospital said, "We are poor people. We cannot afford to buy these drugs. We wish government had provided these drugs. We are able to bu these drugs because we get some (incentive) money after operation." Another woman at the Kolar district hospital said, "We understand that government provides the drugs. But after we came here, we were told to purchase the drugs. We cannot argue (quarrel) with doctors for the drugs. We buy the drugs although we are poor people. Please tell the authorities to provide free drugs to poor people like us."

And three, it was also observed that, to begin with, incentive money was given in full to the tubectomy and laparoscopic tubectomy acceptors. Some of these acceptors distributed the incentive money on their own among the doctors, helpers and ayas. When some acceptors did not give money, doctors and others told the ANMs that their "cases" did not give them "anything". Then at the suggestion of their ANMs, the acceptors distributed their incentive money, some of them the entire incentive money, among medical, para-medical and non-medical personnel. It needs to be pointed out that the ANMs were not taking money from the clients. Fleecing money from the clients by the providers in the PHCs and hospitals is the bane of the health and family welfare programmes in Karnataka.

One ANM from Kudiyanur SC said, "Doctors, nurses and helpers in this hospital expect money from the tubectomy acceptors. We cannot protest against this practice because this has been going on for a long time throughout Karnataka. If money is not given, there will be unpleasantness and services may be delayed or even denied."

Another ANM from Beglihosahalli SC said, "Tubectomy and laparoscopic tubectomy acceptors distribute part of their incentive money among the doctors and nurses. Some of them do this on their own. But if some acceptors do not give money, doctors tell us to adivse them to give money. Even though we do not like this, we tell the acceptors to give part of the incentive money to the doctors, nurses and others."

Family planning clinics at the Vokkaleri PHC were conducted on a day when there were three or four women to accept tubectomy. Of course, the LMO's convenience, too, mattered. The clients came to the PHC around 9 a.m. The headquarter LHV and ANM prepared the "cases". They washed the abdomen of the women with soap and water. They gave the necessary injections. They also gave soap and water enema. Women were tested for diabetes, but not for HIV infection.

The interaction between the LHV and the ANM on the one hand, and the clients and their attendants (relatives) on the other was somewhat formal. The former were most of the time indifferent to, and unconcerned about, the latter. The LMO

performed tubectomies around 4 p.m. after attending to the outpatients and taking rest between 12 noon and 4 p.m. Thus the clients had to wait for some time. The clients said tha they were satisfied with the treatment and services given to them by the providers.

The tubectomy acceptors at the Vokkaleri PHC had two complaints. One was that the LHV, ANM and other helpers demanded and took most of the incentive money. The other was that they were not provided food during their stay at the PHC for six or seven days. They had to make their own arrangements for food: either their relatives who accompanie them cooked food near the PHC or they brought food from restaurants.

One tubectomy acceptor said, "Although I was given (incentive) money for adopting tubectomy, much of it was taken away by the nursammagalu (nurses meaning LHV and ANM). They know that we are poor; yet they demand money from us." Another tubectomy acceptor said, "We were under the impression that we will get food during our stay in the hospital. But they are not giving food. We are cooking food with great difficulty because we did not bring necessary utensils. We cannot afford to buy food from the 'hotels'."

At the first blush it appears strange that the clients did not complain much against the providers' behaviour, facilities and services. But a little reflection will show that perhaps clients' expectations were not high. What

ultimately matters is the gap between clients' expectations and experience. Rural people, illiterate or barely literate, ignorant and poor as they were, lived in unsanitary conditions and led a low standard of life. Add to these the ingrained tolerance and humility of the rural people. All these qualities perhaps made the rural people to have low expectations of, and to remain largely uncritical about, the providers' behaviour, facilities and services.

After adopting tubectomy or laparoscopic tubectomy, many women went to their mothers' homes for resting for a few weeks. The mothers' places of most such women were outside the jurisdiction of the SCs, the ANMs of which motivated them to adopt tubectomy or laparoscopic tubectomy. Even so, the ANMs concerned went to the women and provided follow-up services because they did not want a single dissatisfied acceptor who could ruin their motivational efforts in future.

The proportion of Muslims in the population was higher in the Masthi PHC area than in the Vokkaleri PHC area. All castes and all classes utilised the services at both the PHCs. But Muslims mostly utilised the services at the Masthi PHC and all religious groups equally utilised the facilities at the Vokkaleri PHC.

The MOH of the Masthi PHC was of the opinion that upper class people were clean and courteous. Most people were dirty and rude. "They do not know manners", said the MOH. But

they listened to him to keep the surroundings of the PHC cle
He said that most people were "unrealistic" because they attributed all their health problems to the tubectomy or laparoscopic tubectomy, even though it was adopted years ago. In contrast, the IMO of the Vokkaleri PHC was of the opinion that people who came to utilise the services at the PHC were "somewhat clean" but "we cannot say they are dirty. The are courteous and have good manners. They keep the PHC premi clean. They appreciate my services. I am very strict with them and I treat them equally. I maintain 'Q' system. Even then they appreciate the services which I am providing. Family planning cases attribute every problem to operation (sterilisation) only. Muslims utilise the services better because they want some reason to come out of the house. So they will visit the hospital."

According to the MOH and DMO, people in the two PHC areas had a good opinion about the providers, barring one or two. The MOH at the Masthi PHC said, "old people and poor people appreciate the services better. Youths and rich people are arrogant and they do not know manners." The DMO at the Vokkaleri PHC said, "Generally all the people appreciate our (PHC) services. Drugs provided by the government are not sufficient. When drugs are not available I give prescriptions. This is resented by people, especially youths and rich people."

In general, people's image of the female providers was better than that of the male providers. In fact, many male providers were disliked by the people.

The MOH of the Masthi PHC said, "I am not satisfied with the quality of services provided because there are too many health programmes and there is no time to do justrice to all the programmes." His official jeep was taken away to the taluka hospital at Malur four months ago and he did not have a vehicle to visit SCs and villages in his PHC area. In order to improve the quality of services, he wanted a jeep, more money for the diesel for the jeep and the present transportation allowance of Rs.15/- per tubectomy or laparoscopic tubectomy acceptor to be increased to Rs.45/-. The LMO of the Vokkaleri PHC was by and large satisfied with the quality of services provided. She said, "We provide good quality services in this PHC. I am quite satisfied about them. If there are any shortcomings, they are beyond my control." However, she was of the opinion that quality of services could be improved by appointed a separate doctor to look after the administration of the PHC; the other doctor could provide services to the clients. She further said, "This is a large PHC. The MOH is not there. I have to look after the administration of the PHC and also provide services. If there is MOH who can look after the administration of the PHC, I can concentrate on the services and further improve their quality." Another important suggestion she gave was that adequate and quality drugs should be supplied to the PHCs.

The Medical Officer of Health (MOH) at the Masthi PHC was a Hindu and belonged to the third highest caste (Vaisya).

He was 50 years old. He was married and had three sons. His wife had adopted tubectomy. He has been working as MO for more than 20 years and for more than five years at the Masthi PHC. He chose medical profession because (1) employme was assured, (2) he had aptitude for medical profession, and (3) he wanted to serve the humanity. He did not want to take up any other job even if it fetched him higher salary. This perhaps shows that he was committed to his job. As will be seen later, he was not committed so much to provide services to the clients.

The Lady Medical Officer (LMO) at Vokkaleri PHC was a Hindu and belonged to a Scheduled Caste. She was 42 years old. She was married and had two sons. She had adopted tubectomy. She has been working as LMO for 15 years and for nine years at the Vokkaleri PHC. She chose medical profession to serve the humanity. Like the MO at the Masthi PHC, she too did not want to take up any other job even if it fetched her higher salary. She was also perhaps committed to her job.

The MOH at the Masthi PHC wanted to know about the number of living children before prescribing/advising a particular family planning method to a couple. He said that either couples chose the contraceptive themselves or couples and he discussed and arrived at an agreement regarding the contraceptive that the couples should adopt. The couples who chose the contraceptive themselves were usually educated. But

illiterate couples took his advice. He advised newly married couples to have a child as early as possible and then to adopt a spacing method. He was of the opinion that couples would not adopt any family planning method between marriage and the first child. He said, "society and culture expect the newly married couples to demonstrate their childbearing capacity. Therefore, it is not worth the effort to motivate newly married couples to adopt a spacing method." He advised couples with two or more children to adopt "tubectomy". He said that one should tell the couples only about the advantages of different family planning methods, but not about their disadvantages and side-effects. According to him, "if one tells the couples about disadvantages and side-effects of different family planning methods, they would not adopt any family planning method."

He usually advised couples with one child to adopt IUD and those with two or more children to adopt tubectomy/laparoscopic tubectomy because it would be difficult for couples with one child to adopt nirodh or oral pills. Adoption of these methods required a high degree of motivation. According to him, he used to visit all communities and all SCs, but ever since the PHC jeep was taken away to the taluka hospital at Malur, he was not able to visit remote SCs. He said that some couples were resistant to family planning because of religious reasons (Muslims), blind beliefs, illiteracy, objections from the elders and fear of operation. He was of the opinion that his counselling (motivation) had a definite impact on the acceptance of family planning.

He thought that provision of follow-up services would help the providers to enlist the cooperation of women and couples for MCH and family planning programmes. But he also thought it would be impossible to provide follow-up services to all the MCH and family planning beneficiaries.

According to the MOH at the Masthi PHC, "Targets, especially family planning targets, adversely affected the quality of services and other programmes, including MCH programme." He further said "Targets should be there but workers should not be compelled to achieve them, and no punitive action should be taken against workers if they fail to achieve the targets."

He refused to specify the problems he faced from higher authorities while he provided services to the people. But he said "community leaders and members demand services and drugs, which are sometimes not available in the PHC all the time. They want the doctor to stay at the PHC headquarter

The MOH at the Masthi PHC said that he spent more time on curative services. He did not think that he needed further training in effectively providing MCH and family planning services.

The IMO at the Vokkaleri PHC wanted to know about the marital status of a man or a woman, number of living children, age of the youngest child, blood pressure, diabetes status,

etc. before prescribing/advising a particular family planning method. She said that couples and she discussed and arrived at an agreement regarding the contraceptive that the couples should adopt. She advised newly married couples, and couples with one child, to adopt a spacing method, and those with two or more children to adopt a terminal metho. She, too, was aware that it was difficult to motivate newly married couples to adopt a spacing method. But she said, "efforts should be made to persuade them to adopt nirodh or oral pills." She further said, "one should tell the couples about the advantages, disadvantages and side-effects of different family planning methods because couples can choose the method themselves and they would not get perturbed when they experience side-effects." But she hastened to add that "while telling about the side-effects, they should not be emphasized and that couples should be assured that proper follow-up services would be provided promptly and that side-effects would be cured immediately."

The IMO at the Vokkaleri PHC also advised couples with one child to adopt IUD because "illiterate people would not remember to take oral pills regularly or use nirodh regularly." Moreover, according to her, disposal of used nirodh would be a problem in the rural areas. She, however, wanted newly married couples to use oral pills and nirodh because IUD cannot be adopted by the newly married girls. She advised couples with two or more children to adopt a terminal method.

She said "I visit all the communities and all the SCs because there is a jeep available for me." According to the LMO, Muslims were more resistant than Hindus to the ide and methods of family planning. But she said that Muslim women in one of the areas under the Vokkaleri PHC were receptive to the IUD and medical termination of pregnancy (M she further said that she promptly provided these services.

The LMO at the Vokkaleri PHC was of the firm opinion that it is necessary to provide detailed information about each family planning method to the couples so that they could choose the method which they liked most and they would be aware of the possible complications and would be prepared psychologically to face them.

She said that it was not possible to provide follow-up services to all the MCH and family planning acceptors because the PHC area was large, she was the only doctor at the PHC and she had to look after the hospital also. But she asserted that provision of follow-up services to MCH and family planni acceptors would generate a sustained demand for the services.

She did not face any problems either from higher authorit or from community leaders/members while she provided services to the people.

She said, "I have been forcing the staff to achieve family planning targets because of the pressure from "above" and, as a result, other programmes suffered."

The LMO at the Vokkaleri PHC spent more time on preventive and curative services. Like the MO at the Masthi PHC, she, too, did not think that she needed further training in effectively providing MCH and family planning services.

Like the female health workers, the lady doctor had more sympathy for the clients than the male doctor. The clients, too, had more appreciation for the lady doctor than for the male doctor. Thus, there was reciprocity between the providers and the clients. In the Vokkaleri PHC, a tubectomy acceptor said, "Doctoramma (lady doctor) is a nice person. She has good patience. She answers all our questions and clears our doubts. She treats us well." But an ante-natal mother at the Masthi PHC said, "The (male) doctor is seldom seen in the PHC. He is very impatient. He often shouts at us. What can we poor people do?"

The Process of Sterilisation

It would be interesting to narrate the process of tubectomy from the time a woman is motivated till she comes back to the village after the surgery. As mentioned earlier, ANMs motivate currently married women in the reproductive age for tubectomy while providing antenatal, intranatal and postnatal services. The women are informed about the days on which tubectomies are done in the Malur taluka and Kolar district hospitals.

A day before the operations are done either ANMs collect the women at their respective SCs and take them to the taluk

hospital or the district hospital, as the case may be, or ANMs advise the women to reach the hospitals on their own. Generally, they travel by bus and the women pay their bus fare.

After reaching the hospitals, the ANMs admit the women into the ward by registering their names before 3 p.m. a day before the operations. Lady doctors examin all the women The examination includes general check u BP, urine for albumen/sugar, blood for HB percentage, abdomen palpation, etc. If any woman is late and comes after lady doctors have finished examining women, she has to go back and come the next week.

In the evening, after early dinner, women are given soap and water enema by ANMs for cleaning the bowels. Abdomen preparation is also done by the ANMs.

The next morning only coffee is given to the women. TT, Zyloken and streptopenicillin test doses are given three hours before operation. Operations will start any time between 11 a.m. and 4 p.m. depending upon the convenience of the surgeons. Zyloken injection is given during operation. TT injection is given after test dose. Streptopenicillin injection is given for five days starting from three hours after operation.

On the seventh day sutures are removed and women are discharged with advice not to do hard work or lift heavy weights for a month or so. ANMs take them by bus and leave them at their homes. Then they provide follow-up visits.

As in the case of tubectomy acceptors, women coming for laparoscopic tubectomy are registered. All the examinations are done on the day of laparoscopic tubectomy. Test doses of Zyloken, streptopenicillin and TT injections are given. TT injection is given after test dose, Zyloken during operation and streptopencillin three hours after operation (only once). One or two hours after strepto-penicillin injection, they are discharged. They are sent home by official jeep and their transportation money of Rs.10 is withheld. Before they are discharged, they are given the same advice which is given to the tubectomy acceptors. Then ANMs provide follow-up visits.

The wards and rest rooms are clean. Syringes and needles are sterilised before use on every woman. New gloves are used for every woman. The linen is fairly clean.

Antenatal and Immunization Clinics

As mentioned earlier, antenatal clinics and immunization clinics were conducted together in the PHCs and SCs. Immunization clinics were also conducted in the villages by spreading

information about them in advance during the visits of th ANMs to the villages. The clinics were conducted in the PHCs on every Thursday. But no day was fixed for conduct them in the SCs and villages. As and when sufficient numb of beneficiaries were available, the clinics were conducte at the SCs and in the villages.

Anternatal and immunization clinics in the PHCs genera started around 9 a.m. But that time the peons and ayas arranged chairs, tables and benches. The LHVs supervised t arrangements of vaccines, syringes, iron and folic acid tab steriliser, etc. The MOH/IMO sometimes came at 9 a.m. and sometimes at well past 10.30 a.m. When the pregnant women, infants and infants' mothers came around 9 a.m., they were made to sit on the benches. The infants were first registe by the ANMs. They checked the immunization status of each infant. Then the infants were vaccinated as per requirement Before vaccinating, the arm/hip of each infant was cleaned with cotton swab dipped in boiled water, but not with spirit It was confirmed that there was no supply of spirit.

The mothers were informed that the infants might develo fever and that they should not worry. They were also told to give bath daily to the infants. They were advised to bring the infants for further vaccination after four weeks. They were instructed to preserve the infant's immunization

card safely. The whole activity went for about an hour without much unnecessary talk by either providers or clients.

The antenatal mothers were first registered by the ANMs. Almost all the antenatal mothers were attending the antenatal clinics for the first time. Their height and weight were guessed and entered in the cards and registers. They were given tetanus toxoid (TT) injection and 30 iron and folic acid (IFA) tablets. Only sometimes were the fundal height, urine examination, haemoglobin examination, oedema, etc. taken/done. It appeared that these were skipped when the number of beneficiaries was large.

Only those antenatal mothers who were anaemic and visibly weak were identified as high risk group. They were advised to take nutritious food and postpone the next pregnancy by adopting a family planning spacing method or stop further pregnancies altogether by adopting tubectomy or laparoscopic tubectomy. Virtually no attempt was made to identify high risk groups by para.

Occasionally, after ascertaining the age of the antenatal mothers, information on the number of living children they had and their family planning status was asked for. When any mother said that she had two or more children and that she had not adopted any family planning method, she was advised to adopt tubectomy or laparoscopic tubectomy.

The antenatal mothers were advised to take nutritious food, including green leafy vegetables, milk, eggs, fish, etc. They were told to visit the PHC again after four wee But the providers said that they would not turn up again a the PHCs and that follow-up services would be provided by the ANMs in the villages, The antenatal mothers were also advised to come to the PHCs for deliveries or call the ANMs or trained dais for conducting deliveries.

No IEC aids were used for conveying information. Sometimes the visits of important outpatients to the PHCs distracted the attention of doctors. But such distractions or interruptions were not many and they did not have any effect on the interaction.

The total time taken for interaction varied from one to two hours.

Sometimes the antenatal and immunization clinics were started late and the clients were required to wait. While the doctors, LHVs and ANMs interacted nicely with the clients the ayas who were sending the mothers one by one into the room for TT injection and IFA tablets were rude. The ayas looked impatient and domineering.

Antenatal and immunization clinics were conducted at the SCs also. Some of them were attended by MOH/LMO. The

number of beneficiaries was smaller in the antenatal and immunization clinics conducted at the SCs than in those conducted at the PHCs. The interaction between the providers and clients was warmer, more friendly, more courteous and more lively in the clinics conducted at the SCs than in those conducted at the PHCs. There were informal conversations between providers and clients.

The process of vaccinating infants in the clinics conducted at the SCs was almost exactly the same as that at the PHCs. And the advices given were also the same. But the atmosphere of the clinics conducted at the SCs was different from that of the clinics conducted at the PHCs. The beneficiaries were more free and more relaxed in the clinics conducted at the SCs than in those conducted at the PHCs.

For antenatal mothers abdomen palpation was done to know the height of uterus and position of the baby; urine test was done for albumen and sugar; haemoglobin test was done; blood pressure was also checked; and, oedema was also checked. But height and weight were not measured. TT injection and IFA tablets were given. Information on antenatal care was given. Antenatal mothers were advised to take nutritious food, including green leafy vegetables, milk, eggs, fish, fruits, etc. They were also advised to go to PHC or any government hospital for delivery or call the ANM or trained dais for conducting delivery. But hardly any attempt was

made to identify high risk groups, except advising wome
who were annemic to take nutritious food, and adopt a f
planning spacing or terminal method depending upon the n
of living children they had. Counselling on family plan
was better in the clinics conducted at the SCs than in t
conducted at the PHCs. They were advised to come to the
after four weeks. No IEC aids were used for conveying
mation. There were no distractions or interruptions. Th
total time taken was about an hour. The quality of inter
and services was markedly better in the clinics conducted
at the SCs than in those conducted at the PHCs.

Immunization clinics, but no antenatal clinics, were
conducted in the villages also. The venue of the clinic
was Anganwadi. Where there was no Anganwadi, clinic was
conducted in a school. Invariably, the ANM concerned, wit
the assistance of aya, set up the clinic at Anganwadi. Th
school teacher and the Anganwadi worker went round the vil
advising the mothers to bring their infants for vaccinatio
The process of vaccination adopted and advices given to th
mothers were the same as those adopted and given in the
SCs and PHCs. In the clinics conducted in the villages,
not only were the infants vaccinated against the six killer
diseases, Vitamin 'A' tonic was given to the children aged
3-5 years.

At times, immunization clinics were conducted in the villages by a team of providers comprising one LHV, two or three ANMs, one Male Health Worker and one or two ayas.

It was observed that when an antenatal clinic was set up in one of the villages, most of the people were away working in the fields. The aya went to the fields and brought the women back into the village. The women brought their infants to the clinic and had them vaccinated.

More time was spent on family planning counselling in the clinics conducted in the villages than in those conducted at the SCs and PHCs. More important, the interaction between providers and clients (mothers of infants) was warmer, more cordial, more informal, more friendly and more courteous in the villages than in the SCs and PHCs.

Possible side-effects of different vaccinations were informed to the mothers. On being asked about the side-effects of BCG vaccination informed to the mothers, the ANM from Kudiyanur SC said, " I tell them that after about 40 days of BCG vaccination, there may be scar infection. Then you come to me and I will take you to the doctor at the PHC or you can straightaway go to

the PHC for treatment." On being further asked whether ever child after BCG vaccination will develop scar infection, she said, "Generally if the prick is deep, the child gets scar infection." Another ANM at the Beglihosahalli SC said, "Gen there are no side-effects of BCG vaccination. So I do not tell mothers about the side-effects of BCG vaccination."

ANMs invariably informed the mothers that after polio a DPT vaccinations, children develop fever. One ANM at the Settykothanur SC said,"I tell the mothers that children will develop fever after the administration of polio and DPT vacc nations. I give paracitamal tablets to the mothers and advi them to give one tablet to each child after the administrati of polio and DPT vaccinations." Another ANM at the Arabikot SC said, "I tell the mothers that after polio and DPT childre may develop fever. There is no need to worry. Also, at the site of DPT injection puss may form after one week. I advise them to come to me and get treatment."

All the ANMs said that there were no side-effects of mea

The Sub-Centres.

Of the six ANMs studied, five were Hindus and one was a Christian; and, of the five Hindus, one belonged to a Scheduled Caste, three to backward castes and one to a dominant (forward) caste. Thus, the nursing profession is yet to attract a sizeable number of females from the forward castes. The age of the six ANMs ranged from 27 to 42 years, the average age being 34.5 years. All the six ANMs were married. One was currently pregnant for the first time. Two had one son and one daughter each and both had adopted

IUD. Another also had one daughter and one son, but she had adopted tubectomy. Another had two daughters and adopted tubectomy. The last one had one daughter and one son, but her husband was using condom.

The total experience of the ANMs ranged from about four years to 14 years. And they had been working in the SCs studied from four months to eight years.

Of the six ANMs studied, four chose the profession to "serve the people"; one had no idea and she simply followed the advice of her father and did the nursing course; and, one took to this profession because employment was guaranteed and she could not go for higher education for financial reasons. Three ANMs did not want to take up any job even if it fetched a higher salary. Perhaps they were totally committed to their job. Of the three ANMs who were prepared to take up a new job, two were willing to do so if it fetched a higher salary and one even for the same salary which she was getting. Perhaps they were tired of the arduous nature of ANM's job.

Four ANMs lived at the headquarters of their SCs. One ANM did not live at her SC headquarter because there was no SC building. The SC was started only two years ago. She was living at a distance of 42 kilometres from the SC and commuting daily by bus. The other ANM was living in

Kolar, the district headquarter town, which was at a distan of six kilometres from the SC, although there was a SC building with ANM's residential portion.

Quality of Interaction

As mentioned earlier, investigators accompanied the ANMs for seven days when the latter visited the villages under their respective SCs to provide information and servi to the people, and observed their activities. The interact between the providers and clients was described as "good", "cordial", "informal", etc. As soon as the ANMs approached villages and met villagers going to the farms, they greeted each other. When ANMs approached the households in which there were pregnant women, nursing mothers, infants, young children, potential tubectomy acceptors and women who had recently accepted sterilisation, they greeted the heads of households and other adult members, and the greetings were reciprocated by the latter. In many households, ANMs were offered snacks, coffee, tea, milk and tender coconut water. This is a clear indication that the ANMs were accepted by the community. In the 1950s, when the posts of ANM were introduced, only females belonging to lower castes and Christianity took to this profession. And people belonging to upper castes did not utilise their services. Thus, there was what may be called "structural incongruency". But

now the situation is somewhat different. Although even now majority of the ANMs belong to lower castes and Christianity, people belonging to upper castes accept them and utilise their services.

When the ANMs visited the villages, they visited all the households; they did not make any discrimination between upper caste households and lower caste households in visiting as such. But the fact remains that five out of six ANMs first visited the upper caste households and then the lower caste households. This they did unconsciously. But one ANM consciously visited the scheduled caste and other lower caste households prior to visiting the upper caste households because she believed that the former were more cooperative and in greater need of her services than the latter.

They visited the households containing pregnant women and nursing mothers on a priority basis. This they did perhaps with the purpose of establishing rapport with them and motivating them to adopt tubectomy or laparoscopic tubectomy at the appropriate time. They also visited, on a priority basis, households containing women who had recently accepted sterilisation to provide follow-up services and ensure that they would not become dissatisfied acceptors.

When the ANMs visited the villages, they often carrie ANC and PNC cards to register new cases, oral rehydration solution (ORS) packets, oral pills, condoms, iron and foli acid (IFA) tablets and aspirin tablets for people sufferin from fever, headache, cold and cough. Thus, they provided not only MCH and family planning services, but also treate minor ailments. The study area is a malaria-prone area. Therefore, the ANMs took occasionally blood smears from persons suffering from fever, although this was the responsibility of the male health workers. The blood smears were later sent to the laboratory at the PHC or taluka hospital or district hospital for examination.

Antenatal Services

The antenatal services provided varied somewhat from one ANM to another. Sometimes the antenatal services provided by the same ANM varied from one pregnant woman to another. Generally, the ANMs estimated the height and weig of pregnant women. They examined anaemia, oedema and foeta heart sound. Invariably, they took fundal height. They did abdomen palpation to know the height of uterus and the position of baby. But urine and blood tests (HB %) were not done. Pregnant women were advised to go to PHC or talu hospital at Malur or district hospital at Kolar for these tests. Tetanus toxoid (TT) injections were given on the immunization day.

The ANMs distributed invariably IFA tablets to pregnant women. The IFA tablets were distributed in three instalments (30+30+40=100) so as to avoid wastage. After ensuring that the first instalment of 30 tablets were consumed by a pregnant woman, the second instalment of 30 tablets were given. After ensuring that the second instalment of 30 tablets were consumed by a pregnant woman, the third and final instalment of 40 tablets were given.

A number of useful advices (health education) were given by the ANMs to the pregnant women. The latter were advised by the former to eat nutritious food, including vegetables, especially green leafy vegetables, eggs and fruits, and drink milk. One ANM was observed advising pregnant women to drink more water also. The pregnant women were also advised to cut their nails and keep them clean, to keep a new blade and washed clothes ready to be used at the time of delivery, and to go to PHC or any government hospital for delivery or to call the ANM or trained dai to conduct delivery. But there was not much family planning talk at the time of providing antenatal services.

Delivery Services

Each of the six ANMs conducted two to six deliveries during the study period. And most of the deliveries attended by the ANMs were in the SC headquarter villages. The way

deliveries were conducted varied from ANM to ANM, and fro
delivery to delivery conducted by the same ANM. On the w
the quality of delivery services leaves much to be desire

Some ANMs gave soap and water enema to women before delivery and others did not give. All of them, of course, washed their hands before conducting deliveries. But some washed their hands with soap and others did not use soap. After the delivery, one ANM did not clean baby's eyes, nos and mouth. The ANMs did not use rubber sheet provided in the kit supplied under the Child Survival and Safe Motherh (CSSM) programme to place the mother and baby. After expulsion of placenta, baby was separated. Cord ligature used was prepared using local thread instead of sterilised cord ligature available in the delivery kit. New blade was used for cutting baby's umbilical cord. Some ANMs gave bath to the mother and baby and others did not. Blood clots were removed from the uterus by some ANMs and were not removed by others. Diapers were prepared by using old sari pieces. In one instance, baby was put on a flat bamboo basket used for cleaning foodgrains. One delivery was conducted by an ANM on a mat. After the delivery, the mother was made to lie down on a bed made out of hay (dry grass) and spread on the floor. The ANMs were conducting deliveries like <u>dais</u>. It appeared that it was a problem of both lack of knowledge and lack of proper attitudes to

conduct deliveries. But whenever ANMs were requested to conduct deliveries, they readily obliged.

In one of the SC headquarter villages, a woman devloped labour pains at 1.45 a.m. Her husband came and requested the ANM to conduct the delivery. The ANM agreed readily and went with a disposable delivery kit and a weighing scale. The delivery took place at 4.15 a.m. The ANM came home at 5.30 a.m. after conducting the delivery.

In addition to conducting deliveries, ANMs advised the mothers about the need for, and importance of, breastfeeding babies right from the first day, immunization, infant care, post-natal care, giving bath daily to the babies and mothers, and keeping the surroundings of the mothers and babies clean. The ANMs were enquiring with post-natal mothers whether they were experiencing excessive bleeding. More importantly, the ANMs advised the mothers or elders in the family to take all the babies with a birth weight of less than 2500 grams to the PHC or taluka hospital at Malur or district hospital at Kolar for observation and treatment. After the birth of a baby, ANMs tried and often succeeded in motivating women to accept some method or the other of family planning. Generally, ANMs suggested IUD to women with one child and tubectomy or laparoscopic tubectomy to women with two or more children. The women with two or more number of children were allowed to choose tubectomy or laparoscopic tubectomy. But virtually no attempt

Thus, the ANMs did a lot of family planning talk at the tim of providing delivery services. Perhaps the ANMs were awar that the post-delivery (post-partum) period was the point o highest motivation for family planning.

At the time of a visit to a village by an ANM, one woman wanted medicine to her infant suffering from cough. I was surprising that the ANM advised the woman to give kasay (water boiled with cumin seeds, pepper and turmeric) to the infant. Another woman in the same village wanted medicine from the ANM to her two-year old child suffering from dysent But surprisingly again the ANM advised the woman to give reddish mud water with poppy seeds. Perhaps the ANM was advising the women to give ayurvedic medicine.

Family Planning Services

At the time of their visits to the villages, the subject of family planning was high on the minds of the ANMs. Invariably, they carried with them oral pill cycles and condo but not the IUD kits. In one of the villages under a SC, two women wanted their ANM to insert IUD at the time of her visit. Since the ANM did not carry the IUD kit, she advised the women to visit the SC the next day and have the IUD inserted. The next day one woman came and had the IUD insert But the other woman did not turn up. Two observations can

be made here. One is that had the ANM carried the IUD kit to the village, the other woman also would have adopted the IUD. The other is that the woman was not sufficiently motivated to go to the SC and have the IUD inserted. Incidentally, another woman in the same village wanted the ANM to remove her IUD. But the ANM advised her to come to the SC the next day. She did not turn up at the SC the next day.

The ANMs gave oral pill cycles to women. The oral pill users were not many in number. They did not give condoms to men who were using them. Instead, they gave them to their wives who, in turn, passed them on to their men. There was still some embarassment on the part of men to receive condoms from ANMs, as also on the part of ANMs to give condoms to men. Major part of the attention of ANMs was on women with two or more number of children, who had not yet adopted tubectomy or laparoscopic tubectomy. They approached the women every time they visited villages and often succeeded in making them adopt sterilisation. When once a woman accepted to adopt tubectomy or laparoscopic tubectomy, either the ANM took her to the PHC at Vokkaleri (the MO at the Masthi PHC was not doing tubectomies or vasectomies) or taluka hospital at Malur or district hospital at Kolar a day before the family planning camp day or she asked the woman to come straight to the PHC at Vokkaleri or taluka hospitals or district hospital where the ANM met her and admitted her to

the camp. At the family planning camps, the ANMs were se busy looking after the arrangements for the sterilisation of women from the villages of their respective SCs.

It needs to be emphasized that some women, who were self-motivated, approached the ANMs enquiring about the d and place of availability of tubectomy or laparoscopic tubectomy services. The ANMs gave the necessary informat to the women.

There were quite a few instances in which women were willing to adopt sterilisation, but their husbands and/or fathers-in-law and mothers-in-law were against it. This was particularly true of the Muslims. The ANMs were, ther fore, educating, in addition to women with two or more children, husbands, fathers-in-law and mothers-in-law abou the advantages of a small family and disadvantages of a large family.

The ANMs made it a point to visit the women who had recently adopted sterilisation and provide follow-up servi wherever necessary. If the side-effects of sterilisation were serious, the ANM concerned took the women to PHC or taluka hospital at Malur or district hospital at Kolar for treatment by a doctor. The ANMs were very keen to ensure that no sterilised woman became a dissatisfied acceptor

because they knew that the good image of the programme and the ANM created by 100 satisfied sterilised women could be ruined by one dissatisfied sterilised woman.

There appeared to be a considerable latent demand for medical termination of pregnancy (MTP). Three ANMs took three pregnant women to the district hospital at Kolar on three different days. A lady doctor examined the three pregnant women and performed MTP.

Many a time, ANMs visited Anganwadis and enquired with the Anganwadi workers about the new pregnant women, nursing mothers and fever cases. They also signed in n register kept at the Anganwadis as proof of their visit to the villages.

There was some problem with regard to the timings of the visits of the ANMs to the villages. Invariably, they left the SC headquarter around 10.30 a.m., visited one or two villages, depending upon the size of the villages and distance from the SC headquarter, and returned to the SC headquarter by 2 p.m. or 3 p.m. During this time, many villagers were away working on their farms or as agricultural labourers. One investigator estimated that about 40 per cent of the houses in the villages under a SC were locked when the ANM visited. When a house is locked, ANM puts the date of visit on a circle on the wall by the side of the main door of the house. This is proof to her supervisor, Health Assistant (Female), earlier know as Lady Health Visitor (LHV),

that she visited the house. More often than not, ANMs left in the village information about the date of their next vis so that those who were in need of their services could stay back without going to the farms and receive their services.

The ANMs visited generally every village once in a wee But the villages which were in remote areas and did not hav transportation facility were visited less frequently than t which were accessible easily. As might be expected, people in the SC headquarter villages received services from the ANMs more frequently than those in other villages. This is perhaps the reason for the observation by the investigators that the image of the ANMs was better in the SC headquarter villages than in the other villages under the SCs.

Male Health Workers

As already mentioned, a high proportion of the Male Health Worker posts are vacant in Karnataka. Of the three S selected from the Masthi PHC, only one (Dinneriharohalli) ha a Male Health Worker. He was to provide services not only t the villages under the Dinneriharohalli SC, but also to thos under two other SCs (not covered by the present study). Totally, he was to provide services to 26 villages. Similar of the three SCs selected from the Vokkaleri PHC, only one (Arabikothanur) had the services of a Male Health Worker.

He was to provide services not only to the villages under the Arabikothanur SC, but also to those under two more SCs (not covered by the present study). Totally, he was to provide services to 23 villages. Although they said that they paid, with great difficulty, one visit to each village in a month, one paid one visit each to four villages under the Dinneriharohalli SC during the two-month study period, while the other paid one visit each to three villages under the Arabikothanur SC.

The Male Health Worker providing services to the villages under the Dinneriharohalli SC was 52 years old and married, and had four children. He had 10 years of schooling. His wife had accepted tubectomy. He was living in Dinnerhiharohalli. He was recently trained and promoted as Male Health Worker. He was earlier a peon in the Masthi PHC. His total experience was 27 years, but he has been working as Male Health Worker in the Dinneriharohalli SC for the last 15 months. He did not want to take up another job even if it fetched him a higher salary. The Male Health Worker providing services to the villages under the Arabikothanur SC was 41 years old and married, and had three children. He was a graduate. His wife had accepted tubectomy. He was not living in Arabikothanur; he was living in the headquarter of another SC not covered by the present study. He has been working as Male Health Worker for the last 14 years,

and for the last three years in the present SC. He was willing to take up another job if it fetched him a higher salary.

When the Male Health Workers visited the villages, th went to houses randomly and enquired mechanically about t health of children and adults. They obtained blood smear from people suffering from fever presuming that they migh be suffering from malaria, and sent them for examination their respective PHCs or taluka hospital at Malur or dist hospital at Kolar. They gave chloroquin tablets to peopl suffering from fever. This was called presumptive treatme which means that all fever cases were assumed to be due t malaria. They gave primaquin tablets to those who were confirmed to be suffering from malaria. This was called radical treatment.

It is important to know that the Male Health Workers did not apply spirit to the fingers before obtaining blood smears from people suffering from fever. They did not eve clean the fingers with water. The hands of the people in the villages were generally muddy or dusty as they worked the fields. It appeared that there was no supply of spiri by the Government Medical Stores.

The Male Health Workers tried to impart health educa- tion to people. The health education centered around pers

hygiene and environmental sanitation. They advised the villagers to keep poultry farms at least two kilometres away from the villages.

They also enquired about births and deaths that took place in the villages since their last visit; they also enquired about new antenatal cases and new post-natal cases. They entered the information in the registers carried by them.

They advised recently delivered mothers to get their children immunized. They carried condoms with them to give to the men who wanted to use them, but most of the men were away working on their farms or farm labourers. They did very little talking about family planning.

The Male Health Workers visited the villages from about 9 a.m. to 1 p.m. During this period many people were away working in the fields.

FOCUS GROUP DISCUSSIONS (PROVIDERS)

As decided earlier, two focus group discussions were conducted among the providers, one in each PHC, to capture their perception on quality of care provided at the clinics and the interaction between the providers and the clients. During the discussions, issues such as need for further training, need for method mix and problems faced in providing services were addressed.

The providers were confident that they were fairly well trained for their job. But many of them admitted tha they were trained quite some years ago and that they neede reorientation or even retraining. Some ANMs said that the needed further training in inserting IUDs. They were not quite sure whether they were inserting IUDs properly. The said that they were given training for 15 days in insertin IUDs. But they were trained in batches, each batch contain ing about 50 ANMs. Therefore, they did not receive adequat training in inserting IUDs. Hence the need for further training.. Some ANMs said that they required some more training in immunizing children, pregnant women and nursing mothers. Quite a few ANMs said that they needed further training in conducting deliveries. Some of these ANMs said that they had been trained in conducting deliveries by ANMs but not by doctors. Therefore, they wanted to receive further training in conducting deliveries from doctors. Some providers said that some clients were resistant to the idea and different family planning methods. Therefore, they wanted training in motivating couples to accept family plann ing methods.

As for the need for promoting method mix, there was a set pattern in response. Virtually all the providers echoed that couple with one child should be motivated to use IUD or oral pills or condoms, almost in that order, and those with two or more children should be motivated to adopt tubectomy/laparoscopic

tubectomy or vasectomy. When asked whether they suggested a spacing method for the couples with two or more children and a terminal method to couples with one child with a view to meeting method-specific targets, they all replied in the negative. They said that when couples with two daughters refused to adopt a terminal method because they wanted to have a son, then they suggested a spacing method to them. It was clear from the observations made in the field that more efforts were made by the providers to promote the adoption of terminal methods by the couples with two or more children. The providers were not so much concerned about achieving the targets for spacing methods. But the targets were always achieved. This leads to the doubt whether the performance statistics of spacing methods are all that reliable.

The opinion of the providers about the need for, and possibility of, providing detailed information to clients and its impact on acceptance of contraceptives was divided. Some said that we should take couples into confidence and tell them not only about the advantages of different family planning methods, but also about their disadvantages and possible side-effects so they would not get unduly perturbed when they experience side-effects. They also said that the clients should be assured of proper follow-up services, especially when they experience side-effects. But most said

that clients should be told only about the advantages of different family planning methods, but not about their disadvantages and side-effects. They further said that people already had erroneous notions that they would not be able to work after vasectomy or tubectomy/laparoscopic tube and if they are told about the disadvantages and side-effect many couples would not accept any terminal method. Similarl the providers said that people were under the impression that condoms lead to skin diseases, oral pills to cancer and IUD to heavy bleeding. Therefore, the providers were of the opinion that if clients were told about the disadvant ages and side-effects of different family planning methods, they would not accept any method and targets would never be achieved.

Many providers admitted that they faced some problems from the community in providing MCH and family planning services, These included refusal by about five per cent of pregnant women to take tetanus toxoid injection and by about 25 per cent of the pregnant women to consume IFA tablets. Some pregnant women develop diarrhoea when they take IFA tablets. This may be the reason for their refusal to take IFA tablets. Similarly, some mothers did not want their children to be immunized against measles because of the belief that children should have measles so that they would develop immunity to it later. The providers said

that in providing family planning services they faced resistance not so much from the couples as from the elders. Some of the providers said that the elders "scolded" and drove them away for promoting family planning. They also faced problem in promoting the adoption of terminal methods by the Muslims.

The providers said that most villages were connected by roads and were accessible by public transport. But there were some villages which were not connected by roads and were not accessible by public transport. The providers reached the villages by trekking 4-5 kilometres either from the SC headquarter village or from the nearest bus stop. Some villages were accessible by private transport such as jeep or "tempo" van for which the providers had to pay high fares. The providers experienced more difficulty when they organised immunization clinics in the villages because they had to carry vaccines, equipment, etc. They wanted a jeep to be provided when they organised immunization clinics in the villages.

All the providers agreed that it was very important to provide follow-up services, especially to the tubectomy and laparoscopic tubectomy acceptors. They know fully well that the demand for tubectomy and laparoscopic tubectomy will dwindle down if they do not provide follow-up services. They said they paid three or four follow-up visits to the "operated cases", the first one within one week after "operation"

for dressing. When asked whether they did this only with the purpose of sustaining the demand, the providers answered in the affirmative and added that they were also concerned about the health of the acceptors. They admitted that it was not possible to pay follow-up visits to all the IUD, oral pill and sterilisation acceptors in time. They further said that they provided follow-up visits to all the sterilisation acceptors in time, but not to the IUD and oral pill acceptors. The IUD and oral pill acceptors were provided follow-up visits as and when the providers found time. The providers also said that they paid follow-up visits in time to all the antenatal cases, post-natal cases and immunized children.

One important problem faced by the providers while providing follow-up services to the sterilisation acceptors was that they were not supplied with follow-up drugs and dressings. The providers purchased with their money "band-aid" and nebasulpha powder for dressing the operated wound. Another ANM said that she faced some problems from her supervisors while she provided services. These included non-cooperation from her supervisors who did not provide her with sufficient drugs, vaccines and a jeep to go to villages and organize immunization clinics.

The providers were fully aware that post-natal follow-up could be a good strategy to promote the adoption of tubectomy laparoscopic tubectomy. They succeeded to a great extent in promoting the adoption of sterilisation by providing post-natal follow-up services.

The providers agreed that family planning targets demoralised them and distorted the quality of services. In the monthly meetings at the PHC, while reviewing the percentage achievement of family planning targets, MOH/LMO rebuked the ANMs who were lagging behind in achieving the targets. This rebuke in the presence of other colleagues was regarded by the providers as an "insult" to them. Therefore, they tried to achieve the targets without bothering much about the quality of services. Thus, quality of services was a victim of targets. However, it did not have influence on their recommendation of contraceptives to prospective clients because the major thrust was on the promotion of sterilisation, especially tubectomy/laparoscopic tubectomy.

There were no two opinions among the providers about the need for, and importance of, involving males/husbands in the family planning programme. Some providers said that some special motivational techniques should be developed to make men accept condoms or vasectomy. Others were of the opinion that mass media like radio, TV and film shows should be employed more rigorously in promoting the adoption of condoms and vasectomy. In fact, they were critical that the mass media propagated female family planning methods more often than the male methods. Some of the providers said that in a way females/wives were responsible for lack of demand for condoms and vasectomy because they did not

want their husbands to practice family planning, especially vasectomy, because they were under the erroneous notion that vasectomy would harm their health, adversely affect their working capacity and so on. All the efforts of providing information, education and communication have not eradicated the wrong notions. Condoms were not used for lack of sexual satisfaction and for side-effects such as irritation. Also, the quality of the condoms supplied until recently was considered poor. Some of the old and experienced providers said that in the past there was demand for vasectomy but this demand almost completely disappeared because wives of many vasectomy acceptors became pregnant and this created a serious social problem. The main reasons for this "failure" were two. One was that in mass vasectomy camps, vasectomies were not done properly. The other was that men were not given seven or eight condoms to be used after vasectomy and when given they were not used by men. As a result, wives of some vasectomy acceptors became pregnant. Thus both males/husbands and females/wives believed that tubectomy or laparoscopic tubectomy was the best family planning method. One of the important suggestions offered by the providers to involve males/husbands in the family planning programme is that Male Health Workers should be given targets and asked to motivate males to adopt condoms or vasectomy.

FOCUS GROUP DISCUSSIONS (BENEFICIARIES)

Focus group discussions were also conducted among the eneficiaries. As decided earlier, two focus group dis- ussions were conducted per SC. These two focus group dis- ussions were conducted in the same village, one in the central art of the village where generally most of the people elonging to the upper castes and classes were concentrated nd the other in the peripheral area of the village where enerally people belonging to Scheduled Castes/Scheduled Tribes nd other lower castes and classes lived. Thus, in all, 2 focus group discussions were held among the beneficiaries. uring the discussions issues such as clients' expectation f services, accessibility to government and private clinics nd counselling by the providers were addressed. What follows the analysis of the points that emerged in the focus oup discussions among the two types of beneficiaries.

It may be mentioned straightaway that the focus group scussions conducted in the central parts of the villages re attended by a larger number of beneficiaries than those nducted in the peripheries of the villages. Of course, e population of upper castes and classes living in the ntral parts of the villages was larger than that of lower stes and classes living in the peripheries of the villages. re important, beneficiaries from the central parts of the

villages were more vocal and more actively participated in the discussions than those from the peripheries.

The beneficiaries, especially from the central parts of villages, said that for a range of reasons they preferred to go to private hospitals for health care. One of the reasons was that the doctors in private hospitals were readi available and they were not required to wait for a long time But doctors in government hospitals were not readily availab and they required to wait for a long time. Some beneficiari said that in government hospitals, only tablets were given but not injections, and the tablets were not effective in giving relief from suffering. Others said that doctors in government hospitals gave prescriptions and they had to go and buy the tablets and injections and come back to the doctors for taking the injections. This way more time was wasted and day's wages were lost, especially of the people who accompanied the patients. But in private hospitals, doctors gave tablets and injections immediately and people who accompanied the patients could go to work without the loss of the day's wages. In government hospitals, doctors and nurses demanded money for treatment. Paramedical staff in government hospitals were very "rude" to the beneficiaries But, in private hospitals, both medical and paramedical staff were courteous and nice. In government hospitals doctors advised beneficiaries to make 4 to 5 visits to the

hospitals even for simple fever and headache, whereas in private hospitals, only one or two visits were sufficient. Some beneficiaries, especially from the peripheries, said that rich people went to private hospitals and poor people to government hospitals, though the latter knew that even after four or five visits to government hospitals they did not get relief from suffering.

Interestingly, people preferred to go to government hospitals for family planning services for two or three main reasons. For one thing, government hospitals were well "equipped" to provide family planning services, whereas most private hospitals were not well equipped and were not providing family planning services. Secondly, the beneficiaries said, ANMs gave them information on different family planning methods, helped them in getting family planning services in the government hospitals and provided follow-up services. And thirdly, incentives were provided for adopting terminal methods in government hospitals.

The beneficiaries said that doctors from PHCs should regularly visit SCs and provide services to the people living in remote villages. They should not be required to go to PHCs or other government hospitals or private hospitals which were located far away from their places. They said that they should be given effective and "advanced"

medicines, especially injections, free of cost so that they could get relief immediately from their suffering. Many potential family planning acceptors said that after "operation" (sterilisation), they should be given "very good" tonics free of cost so that they could recoup their strength early. They also wanted substantially large incentives for sterilisation acceptors to compensate fully the wages foregone by them. Thus services from qualified doctors free and effective medicines and injections and large incentives for sterilisation acceptors were considered as good health and family planning services.

The number of government and private clinics known to the people and their distance varied from village to village. For some villages government hospitals (PHCs) were closer than private hospitals, while for others both government and private hospitals were at the same distance. The distance of a PHC or other government hospital to villages varied from three to 18 kilometres and that of a private hospital from 8 to 22 kilometres. Most of them were functioning regularly. While in private hospitals health workers were available at scheduled time, they were not available in all the government hospitals at scheduled time.

The beneficiaries said that the providers gave all the information requested, disseminated information on different family planning methods and explained how to use them. But

some beneficiaries said that they were told about possible side-effects of different family planning methods, others said that they were not told about them. All the beneficiaries said that if complications occurred, they were advised to go to PHC or a government hospital or call the ANMs.

The beneficiaries said that the providers were regular in conducting clinics at the PHCs, but not at the SCs. The doctors at the PHCs were not visiting SCs regularly and, therefore, clinics were not conducted regularly at the SCs. But the beneficiaries said that the ANMs were more or less regular in paying field visits. They further said that the ANMs frequently conducted immunization clinics in the villages. The beneficiaries were informed well in advance about the date of visits of the providers and also about the date of immunization clinics. The providers treated the clients with courtesy and affection. Similarly, the clients treated the providers with respect and affection. The providers were frequently entertained by the clients in their houses over snacks, coffee, tea, milk and tender coconut water.

The beneficiaries confirmed that the ANMs advised them on follow-up activities. They further confirmed that the ANMs paid follow-up visits to the clients. When the providers visited the clients, the former inormed the latter about the date of their next visit, including

follow-up visit. The beneficiaries said that the ANMs did think that the follow-up visits were necessary.

Most of the people said that they were satisfied with the services provided in the outreach, that is, in the villages, but not with the services provided in the PHCs. They said so because with the limited time and resources available to the ANMs, they were doing a good job; but the doctors and nurses in the pHCs demanded money, did not provide services promptly, did not give effective medicines and injections and were very rude. However, most of them said that they would recommend the services to their friends. The beneficiaries gave a number of suggestions to improve the services. One is that they wanted a PHC to be set up close to their villages, failing which they wanted the doctors in the PHCs to visit the SCs at least once in a week so that they could receive services from qualified doctors. They wanted facilities to be provided in the SCs for treating snake bite cases. Incidentally, during the study period there were three snake bite cases in the area of Vokkaleri PHC, but treatment was not available at the PHC. Two cases took treatment at the district hospital, Kolar, and survived; and, one case took traditonal treatment and died. They also wanted modern and effective medicines and injections to be given free of cost. For family planning acceptors, especially sterilisation acceptors, they wanted tonics to be given free of cost and larger monetary incentives.

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Annexure I

Names and Population of the Villages Served by the Three Selected SCs Under the Mastid PHC and Their Distance from the SC Headquarters

Name of SC/Village	Population (1994)	Distance from SC Headquarter (Km.)
1. Dinneriharohalli(SC)	980	0
2. Thirumalahatty	545	1
3. Mattanakapara	141	4
4. Hobbatty	392	3
5. Niddadagatta	428	1
Total	2496	
1. Kudiyanur (SC)	2000	0
2. Halakempanahalli	57	3
3. Aranighatta	400	4
4. Chamundaraayanapuru	381	9
5. Gunur	207	11
6. G. Kappa	543	10
7. Ramapura	500	4
Total	4088	
1. Santhehalli (SC)	773	0
2. Turugalur	122	1.5
3. Manishettihalli	350	3
4. Ramanathpura	130	4
5. Sonnapanahatti	560	4
Total	1935	

Annexure II

Names and Population of Villages Served by the Three Selected SCs Under the Vokkaleri PHC and Their Distance from the SC Headquarters

Name of SC/Village	Population (1994)	Distance from SC Headquarter (Km.)
1. Arabikothanur (SC)	1094	0
2. Nagalapura	263	5
3. Cheluvanahalli	607	4
4. Chunchadenahalli	545	2
5. Pennashettahalli	517	6
6. Kendhatti.	564	4
7. Madiwala	50	4
Total	3640	
1. Beglihosahalli(SC)	1531	0
2. Chathrakoodihalli	1422	2.5
3. Choolaghatta	657	5
4. Beglibenatenahalli	580	1.5
5. Singoondahalli	499	3
6. Lakshmisagara	380	5
Total	5069	
1. Settykothanur (SC)	930	0
2. Bettabenajenahalli	480	0.5
3. Chikkanahalli	270	0.75
4. Bettahalli	180	1
5. Mangasandra	840	5
6. Choudadevanahalli	280	6
7. Kallandur	502	7
8. Settyganahalli	855	0.5
Total	4337	

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